STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0054		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED 06/22/2016	
		B. WING				
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	مالالمحس	
MT HOI	ME HEALTH AGENCY		TREET NV		7/13/	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
An annual licensure survey was conducted from June 16, 2016, through June 22, 2016, to determine compliance with Title 22B DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provides home care services to two hundred and fifty-three (253) patients and employs four hundred and fifty (450) staff. The findings of the survey were based on observations, record reviews and interviews with current patients and staff. The following are abbreviations used within the body of this report: DON - Director of Nursing HCA - Home Care Agency		H 000	VMT Home Health Agency makes its be effort to operate in substantial compliance both Federal and State laws. A Statement Deficiency (SOD) does not constitute an admission or agreement by any party, its officers, Directors, employees or agents a truth of the facts alleged or the validity of conditions set forth on the Statement of Deficiency Report. The SOD is prepared and/or executed solely because it is requirely Federal and State laws.	e with of sthe		
	ensure that each pa services has the foll (c) To be informed of following: (2) Whether services insurance, Medicaid	ency shall develop policies to tient who receives home care owing rights: rally and in writing of the sare covered by health, Medicare, or any other tent of uncovered expenses	H 294			
:	Based on record rev determined that the policy by to inform the writing whether servi	net as evidenced by: iew and interview, it was HCA failed to follow their ieir Patient orally and in ces are covered by health , Medicare, or any other				

	Regulation & Licensir NT OF DEFICIENCIES	Administration (X1) PROVIDER/SUPPLIER/CLIA	T (X2) MULTIE	PLE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		3:		PLETED
	······································	HCA-0054	B, WING		06/2	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
VMT HO	ME HEALTH AGENCY		STREET NW			
WASHINGTON, DC 20001 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
H 294	Continued From pa	ge 1	H 294	1).		08/15/2016
	for which the patien twenty (20) patients services. (Patient #2 The finding includes On June 16, 2016, a HCA policy "N0-3.00 and Responsibility"			I. VMT Home Health Agency has iden the beneficiaries that did not have a ful completed financial responsibility form the admission process. VMT will inform the beneficiaries iden the deficiency orally and in writing wh services are covered by health insurance Medicaid, Medicare, or any other source the extent of uncovered expenses for we patient may be liable.	Illy In during Intified in Bether See, Sees, and Which the	
	covered by Medican informed of charges be liable." 1. On June 16, 2016 Patient #2's clinical titled "Service Agree Acknowledgement." found a section titled that was to be compthe patient of their firservice. This section 2. On June 17, 2016 Patient #4's clinical ritiled "Service Agree Acknowledgement." found a section titled that was to be compthe patient of their firservice. This section 3. On June 17, 2016 Patient #5's clinical ritiled "Service Agree Acknowledgement." found a section titled that was to be compthe patient #5's clinical ritiled "Service Agree Acknowledgement." found a section titled that was to be compthe that was to be comptited that was to be	e or other payer to be for which the beneficiary may 6, at 12:45 p.m., review of record revealed a document ment and Within this document is d'Financial Responsibility'' leted on admission informing nancial responsibility for the news left blank. 6, at 10:00 a.m., review of record revealed a document ment and Within this document is l'Financial Responsibility'' leted on admission informing nancial responsibility for the news left blank. 6, at 11:30 a.m., review of record revealed a document	X	II. All staff and clinicians will be re-ed on the admission process, with an empty placed on the beneficiaries' rights and responsibilities. The financial responsities section of the admission process will be reinforced during the in-service session including highlighting the importance of documenting completely. The Professional Staff Coordinator will continuously perform quality checks or completed beneficiary admission packet every beneficiary, to ensure proper comand documentation of the beneficiaries and responsibilities upon submission. Moving forward, Clinicians will compadmission packets with proficiency and thorough completeness. The Health Information Specialist will completed admission packets to ensure form is filled accurately before it is file in the beneficiaries chart.	hasis bility e 1, of I n et for npletion rights lete the I review the	07/30/2016

Health Regulation & Licensin	ng Administration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
	HCA-0054	B. WING		06/22/2016
NAME OF PROVIDER OR SUPPLIER STREET AL		DRESS, CITY,	STATE, ZIP CODE	.4
VMT HOME HEALTH AGENCY	,	TREET NW TON, DC 2	0001	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETE
meeting with the Do revealed that the "S Acknowledgement" RN upon admission supervisor also agr Agreement and Ack in clinical records # and stated that the	on was left blank. at 3:30 p.m., a face to face ON and clinical supervisor Service Agreement and was to be completed by the a. The DON and clinical eed that the "Service knowledgement" forms found 2, #4, and #5 were left blank of will have to in-service the ing the completion of this	H 294	III. In an attitude of continuous completed admission packets to ensure completed admission packets to ensure compliance and complete documentati audit would include the section indicate beneficiaries 'financial responsibility as services provided by VMT. A sample size of 10% will be assessed determine compliance and will be the benchmark for any modification of the going forward. The audits will be over the Administrator, or whoever is designed.	ndits of e proper fon. The ting the for to e audits eseen by
ensure that each paservices has the following services has the following services has the following that the with the patient's plant of the finding includes that the policy on patient's rand treatment accoone (1) of fifteen (1) sample. (Patient #4) The finding includes	gency shall develop policies to atient who receives home care lowing rights: ment, care and services agency/patient agreement and an of care; met as evidenced by: view and interview, it was HCA failed to follow their ights by failing to provide care rding to the patients POC for 5) active patients in the	H 300	2). I. The Director of Nursing at VMT wi educate all nurses/clinicians to ensure compliance with the approved visit fr In an attitude of continuous compliance will use visit ranges on the plan of car skilled service visits, in order to maxin flexibility. The visit ranges will appear plan of care for both new admissions a ordered recertification. The skilled visit will be indicated on the of care, and show a visit range of 1-3 week for the current certification period will ensure that the visit range on the beneficiaries' plan of care correlates we visits completed during any given were If the visit frequency is not met for a pweek, a missed visit note will be completed with the missed visit note will be completed visit note visit note visit note visit note v	equency. e, VMT e for all mize r on the and he plan visits/ od. 07/30/2016 dinator vith the ek. particular pleted to
interview with the D	on revealed that the agency's na Sunday and ended on a			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0054	B. WING		06/22/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
VMT HOME HEALTH AGENCY	, 901 1ST 5	STREET NW	1	
THE TOME HEALTH AGENCY	WASHING	STON, DC 2	20001	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETE
p.m., review of the a "Beneficiaries Right revealed that the be receive home care with physician order specifies the service duration." On June 17, 2016, Patient #4's clinical certification period of 2016. Further review orders included skill times a week for nin management. Review orders during this certific ation period of 2016, one time skilled nurse vision week on April 22, 2017-23, 2016, one time during the week of May May 29, 2016, to June 200N and clinical supagency will use a rar avoid such mistakes	ally, on June 17, 2016, at 2:00 agency's policy on is and Responsibilities" aneficiary has the right "to that is provided in accordance is with a plan of care that as and their frequency and at 10:00 a.m., review of record revealed a POC with a of April 20, 2016, to June 18, we revealed that the physician ed nursing services two (2) are weeks for Foley catheter ew of the skilled nursing riffication period revealed that ited the patient one (1) time a 2016, during the week of April in a week on May 20, 2016, May 15-21, 2016, and one 30, 2016, during the week of ine 4, 2016. In the DON and clinical 21, 2016, at 3:00 p.m., the pervisor stated that the inge in projecting visits to	H 300	III. Moving forward, VMT will perform quality audits on a sample size to meast compliance. VMT's Quality Assurance coordinator will perform the audits to eithat the frequency ranges shown on the care and followed accordingly. A sample size of 10% will be assessed determine compliance and will be the benchmark for any modification of the going forward. The audits will be over the Administrator, or whoever is design	ure ensure plan of to audits seen by
patient at least every		H 430	3). I. VMT is unable to retrospectively cordocumentation of a 62-day summary reeach recertification period. Moving for VMT will begin to enforce that a 62 da summary report is written for every ski beneficiary, and sent over to their prima	port for ward, y Illed

	NT OF DEFICIENCIES FOR CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G:	(X3) DATE COMP	PLETED
		HCA-0054	B, WING_		06/2	2/2016
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE		
/МТ НО	ME HEALTH AGENCY		STREET NV STON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)) BE	(X5) COMPLET DATE
	Based on record revialled to review, evareport to the physici provided for nine (9) sample at least ever #8, #9, #10, #11, #1 The findings include During an interview supervisor on June revealed that the ag skilled services as odd not evaluate, review report to the patient. 1. On June 17, 2016 Patient #6's clinical istart of care date of certification period of 20, 2016. Further reaforementioned POO pertinent diagnoses coronary artery diservices. The attending physic following SN service. "[SN] to perform cli update client's plan of management reconding edde"	met as evidenced by: view and interview, the HCA duate and send a summary an of the skilled services) of fifteen (15) patients in the ry 62 days. (Patients #6, #7, 2, #13 and #15) with the DON and clinical 21, 2016, at 3:00 p.m., it was ency's nurses had performed ordered. However, the agency view and/or send a summary s physician as evident below: 6, at 1:00 p.m., review of record revealed a POC with a October 26, 2015, and a of October 26, 2015, to April view of the record and the C revealed that the patient's included: hypertension, ase and diabetes mellitus. cian orders included the is: ent's physical assessment, of care, and teach on disease cile medications as 6, at 2:30 p.m., review of record revealed a POC with a May 4, 2014, and a f September 25, 2015, to July	H 430	II. Reinforcements will be made to all VMT Home Health Agency on the impof completing a 62- day summary on sheneficiaries in and efficient and timely manner. Moving forward VMT's Professional State Coordinator will track all 62-day summare ports with a spreadsheet to ensure the completed and sent to respective primare providers in a timely manner. III. Moving forward, VMT will perform quality audits on a sample size to meas day summary compliance. VMT's Health Information Manager will perform the ensure that a 62-day summary is complementiciaries who receive skilled service indicated. A sample size of 10% will be assessed determine compliance and will be the benchmark for any modification of the going forward. The audits will be over the Administrator, or whoever is designed.	Staffing hary ey are rry care mure 62-lth audits to leted for ces as to audits seen by	07/30/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0054	B. WING		06/22/2016
NAME OF PROVIDER OR SUPPLIER	STREET AL	DORESS, CITY, S	TATE, ZIP CODE	1,
VMT HOME HEALTH AGENC	Y	STREET NW GTON, DC 20	001	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	IN SHOULD BE COMPLET E APPROPRIATE DATE
H 430 Continued From pa	age 5	H 430		
faforementioned PC pertinent diagnoses	eview of the record and the DC revealed that the patient's s included: hemiplegia, type 2 hyperlipidemia and major er.			
The attending phys following SN service	sician orders included the es:			
update client's plan	client's physical assessment, of care, and teach on disease noile medications as			
Patient #8's clinical start of care date of certification period December 9, 2016 and the aforement of patient's pertinent of the second patient p	16, at 9:30 a.m., review of record revealed a POC with a f January 10, 2016, and a of January 10, 2016, to Further review of the record oned POC revealed that the fliagnoses included: multiple sion, depression, obesity, and			T A
The attending physical following SN services	ician orders included the es:			
update client's plan	lient's physical assessment, of care, teach on disease are and reconcile medications			
Patient #9's clinical start of care date of certification period of	16, at 11:00 a.m., review of record revealed a POC with a October 22, 2012, and a of October 22, 2015 to July 28,			
aforementioned PO- pertinent diagnoses failure, asthma, hyp	of the record and the C revealed that the patient's included: congestive heart ertension, cervical pain and			
th Regulation & Licensing Adminis		890 544	GY11	If continuation sheet 6 c

Health Regulation & Lice	ensing Administration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0054	B. WING		06/22/2016
NAME OF PROVIDER OR SUPP	LIER STREET	ADDRESS, CITY, S	TATE, ZIP CODE	
VMT HOME HEALTH AGE	NCY	STREET NW IGTON, DC 20	001	
PRÉFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE
H 430 Continued From	n page 6	H 430		
anemia.	7	í		
The attending profollowing SN se	physician orders included the ervices:			
" [SN] to perfor	rm client's physical assessment,			
update client's	plan of care, feach on disease nd care and reconcile medications	5		
Patient #10's cl a start of care of certification per 2016. Further re aforementioned pertinent diagno	2016, at 12:30 p.m., review of inical record revealed a POC with late of August 6, 2012, and a iod of August 6, 2015 to June 15, eview of the record and the I POC revealed that the patient's oses included: end stage renal es 2, osteoarthritis and peripheral e.			
The attending p following SN se	hysician orders included the rvices:			
update client's p	m client's physical assessment, plan of care, teach on disease nd care and reconcile medications			
Patient #11's clina start of care description period certification period certification period certification period certification period certification patient's pertine gout, cardiac irrespondent certification cardiac irrespondent certification certifica	2016, at 1:45 p.m., review of nical record revealed a POC with ate of November 26, 2015, and a od of November 26, 2015, to 6. Further review of the record entioned POC revealed that the nt diagnoses included: articular egular rhythm, defibrillator ertension and joint pains.			
The attending pl	hysician orders included the	-		

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING:	E CONSTRUCTION		E SURVEY IPLETED
W. C. W.		HCA-0054	B. WING		06/	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VMT HO	ME HEALTH AGENCY	901 1ST S	STREET NW			
		WASHING	STON, DC 20	0001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
H 430	Continued From page	ge 7	H 430			
	update client's plan management and ca as needed" 7. On June 21, 201 Patient #12's clinica a start of care date of certification period of October 14, 2016. Frand the aforemention patient's pertinent dinheart failure, end start hypertension, gout, and the aforemention of the start failure, and start failure, an	and bipolar disorder.				
	following SN service "[SN] to perform cli- update client's plan of	sian orders included the s: ent's physical assessment, of care, teach on disease re and reconcile medications				¢
	8. On June 21, 2016 Patient #13's clinical a start of care date of certification period of September 27, 2016 and the aforemention patient's pertinent dia	generalized pain, and				
	The attending physic following SN services	ian orders included the				
	update client's plan o	ent's physical assessment, f care, teach on disease re and reconcile medications				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		HCA-0054	B. WING		06/22/2016			
	/MT HOME HEALTH AGENCY 901 1ST S			ADDRESS, CITY, STATE, ZIP CODE I STREET NW NGTON, DC 20001				
(X4) ID PREFIX TAG	I) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				D BE COMPLETE			
H 430	Continued From pa	ge 8	H 430					
	as needed"		1					
	9. On June 21, 201	6, at 1:00 p.m., review of						
	Patient #15's clinica	I record revealed a POC with	-					
		of September 24, 2009, and a of September 30, 2015, to						
	September 28, 2018	6. Further review of the record aned POC revealed that the			A			
	patient's pertinent d	iagnoses included; essential						
	nypertension, cortice and HIV.	al blindness, type 2 diabetes						
	The attending physic	cian orders included the			1			
	following SN service							
	" [SN] to perform cl	ient's physical assessment,	1					
		of care, teach on disease are and reconcile medications						
	as needed"	are and resortance metalogueria			1			
		with the DON and clinical						
		21, 2016, at 3:00 p.m., the going forward; the agency will						
	review and evaluate	the skilled services provided.						
	summaries to the pa	ency DON will send evaluation attent's physician.						
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